LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

TB TIMES

October, 2000 | Volume 12 Number 10

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Nursing Changes At TB Control

The Big **"C"** has finally arrived within the Nursing Section of the Tuberculosis Control Program. There are many **"changes"** currently underway at Tuberculosis Control--changes that were inevitable and necessary in order for progress to be made. These changes foster an atmosphere of growth and help to focus our direction as we work toward accomplishing the overall program mission of *Tuberculosis Elimination*. Tuberculosis Control Nurses are now under the direction of one Nurse Manager, Ms. Flora Lamb.

Ms. Lamb adds a wealth of supervisory and administrative experience to the program. Previously, she was the nurse manager of the Refugee/CBO Unit during four of her eight years at Tuberculosis Control. Her current responsibilities include interpreting and directing the implementation of nursing philosophy and objectives, developing nursing operations, work methods, and procedures, establishing standards for quality and quantity of work, and establishing standards for care and practice. Her ability to interface with community groups and private providers is one of her greatest assets. She is a strong advocate for having TB Control Nurses accessible to the public and private sectors through continuous, open communication. To assist her in her supervisory and administrative duties, she works closely with five Program Specialists: Ms. Susan Hamusek, Ms. Linnie Henry, Ms. Grace Huang, Ms. Socorro Kirk, and Ms. Jeanne Soukup.

Ms. Susan Hamusek supervises the contracted Community Based Organizations liaison nurses. These liaison nurses serve as tuberculosis consultants to ten CBOs. She also oversees the TB Control Nursing Educational Unit, including the ERN Program. Ms. Hamusek coordinates and provides health education inservices to nurses and other professionals in the private and public sector and also works closely with the Tuberculosis Control Health Education Unit.

Ms. Henry is responsible for the supervision and direction of the activities of seven Health Center Assistant Program Specialists (APS). The Health Center APSs are primarily involved in continuous quality improvement of tuberculosis cases, suspects, contact investigation, and for conducting other TB- related activities. The Health Center APSs continue to provide on-site expertise, consultation, staff development/training, and assistance to staff at all levels. In addition, they assist staff in the Service Planning Areas (SPAs) and the TB Control Program by ensuring that required TB activities are reported accurately, appropriately, and in a timely manner.

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Upcoming Conferences

- November 3, 2000 — 9:00 am - 10:30 am
  Orthopaedic Hospital - Andrew Norman Hall
  "An Update of TB Related Issues From the L.A. County Public Health Laboratory"
  Andrea Linscott, PhD., Public Health Laboratory Technical Supervisor

  10:30 am - Noon
  Orthopaedic Hospital - Crowe Room
  Physician Case Presentations
  Stephen Puentes, M.D.

  10:30 am - 11:30 am
  Orthopaedic Hospital - Andrew Norman Hall
  ERN Quarterly Inservice
  "Good Nutrition and the Family"
  Cindy M. Agy, M.P.H., R.D., Nutritionst II

- November 9, 2000 — 9:00 am - 12:00 pm
  TB Control Headquarters Room 506A
  Mantoux Training Class
  (Pre-registration required - please call 213-744-6229 for information)

- November 17, 2000 — 9:00 am - 11:00 am
  Orthopaedic Hospital - Andrew Norman Hall
  TB Planning Council
  (Physician Case Presentation & Journal Article Review at TB Control is cancelled due to Planning Council Meeting)

- December 6, 2000 — 9:00 am - 4:00 pm
  Santa Clara Convention Center-San Jose, CA
  Tuberculosis Update Course
  Sponsored by the Francis J. Curry National TB Center
  For more information or to register for this free course, call (415) 502-4620

Nursing changes, from cover

Ms. Grace Huang oversees the Refugee Health Program and assures that refugee activities are implemented according to the State's guidelines and regulations. She is responsible for the supervision of one APS and two refugee teams located at Hollywood-Wilshire Health Center and Central Health Center. The refugee staff provides comprehensive health assessments for approximately 250 newly arriving refugees each month and includes public health nurses, registered nurses, health education assistants, community workers, interpreters, and clerical support staff. Ms. Huang interacts frequently with the Office of Contracts and Grants and with Financial and Health Center Administrative Staff.

Ms. Socorro Kirk oversees activities of the External Health Care System, working with several emerging health models in Los Angeles County that serve the medically indigent population. These health facilities consist of twenty-three personal health service clinics and one-hundred eleven Public-Private Partnership and Community Based Organizations. Ms. Kirk is responsible for providing consultation and education to these facilities and assisting in the improvement of reports of tuberculosis suspects/cases, submitting tuberculosis screening forms and integrating treatment of Latent TB Infection (LTBI) into the primary care model. Referral mechanisms are maintained and accountability lines defined.

Ms. Jeanne Soukup directs, supervises, and coordinates activities for the Surveillance Assistant Program Specialists. They provide tuberculosis consultation and facilitative reporting of patient admissions and participate in discharge planning/approval for private medical doctors and other public/private providers or agencies. Ms. Soukup oversees the hospital liaison nurses who serve as a tuberculosis resource person to hospital and health care workers, providing discharge consultation for patients diagnosed with tuberculosis. These liaison nurses also coordinate tuberculosis discharges with public health centers in the SPAs and with other health care providers. Ms. Soukup supervises MDR nurses who serve as consultants for MDR tuberculosis patients and HIV liaison nurses who coordinate tuberculosis HIV activities with community based organizations.

Despite these changes in the organizational structure, the high quality of service that has always been provided and maintained by Tuberculosis Control Program staff is not diminished. The changes have created an atmosphere for more *innovation* and for a *revitalized* effort toward the commitment to promote higher levels of program performance and to establish stronger working links with other County health programs and public health centers.

We encourage the public and private sectors to continue a dialogue with TB Control Program staff regarding any issue concerning tuberculosis. You may reach us at (213) 744-6191 to collaborate in the care of tuberculosis patients.

(L to R) Flora Lamb, Socorro Kirk, Grace Huang, Linnie Henry, Jeanne Soukup, Susan Hamusek

CASE REPORT REMINDER!

As the year rapidly draws to a close, TB Control would like to remind everyone to update their casework and to report all TB confirmations as soon as possible. **All cases need to be confirmed by December 31, 2000** in order to be accurately included in the case count for 2000. As of October 12, 2000, there were 100 culture positive TB suspects that were not confirmed. TB Control urges everyone to submit and/or follow-up any outstanding paperwork. If you have any questions about reporting, call TB Control at 213-744-6160.

CTCA Adapts Guidelines for Targeted Tuberculin Testing

At the 32nd Bi-Annual Conference of the California Tuberculosis Controllers Association (CTCA), held on September 25 and 26 in Orange County, TB Controllers voted to adopt guidelines for Targeted Skin Testing and Treatment of Latent Tuberculosis Infection in Adults and Children. While largely based on the American Thoracic Society/Centers for Disease Control (ATS/CDC) recommendations issued in June 1999, the California Department of Health Services/ CTCA Joint Guidelines differ in several ways, owing to the different epidemiological patterns of tuberculosis in California. As an example, in regard to tuberculin skin testing, the CDC recognizes 15 mm of induration as a cutoff for low-risk persons with no risk factors for TB. However, because of the high incidence of tuberculosis in California, CTCA recognizes 10 mm as positive in all persons who do not meet high-risk criteria for 5 mm of induration. Another difference between federal and state guidelines is in treatment of latent infection in TB class 4 patients. According to CDC guidelines, the acceptable regimen for such patients is four months of rifampin with or without isoniazid. In contrast, CTCA recommends that rifampin *and* isoniazid both be used when treating class 4 patients for latent TB infection.

Led by CTCA President Dr. Stephen Puentes, the theme of the conference was “Moving Toward TB Elimination,”highlighting the recently released report of the Institute of Medicine (IOM). The report, entitled “Ending Neglect: The Elimination of Tuberculosis in the United States” reviews concepts learned after tuberculosis became largely ignored in the 1960s through the early 1990s, and suggests recommendations for its elimination in the United States. Dr. Lawrence Geiter, PhD, the editor of the IOM report, addressed the CTCA as the keynote speaker. In his speech, Dr. Geiter outlined the major highlights of the report. Dr. Paul Davidson participated in a response panel comprised of tuberculosis control officials from the federal, state, and local levels. In his response, Dr. Davidson addressed the targeting of foreign-born persons with latent TB infection. He acknowledged the difficulty in the quest to eliminate tuberculosis in such a large and diverse county as Los Angeles. He further questioned the availability of resources to effectively screen and treat all immigrants with latent TB infection without development of better diagnostic tests and treatment regimens. Dr. Davidson also pointed out that treatment of TB is increasingly becoming a specialty, as alternative regimens become available and the incidence of TB steadily decreases.

> *“Treatment of TB is increasingly becoming a specialty as alternative regimens become available and the incidence of TB steadily decreases.”*
> *--Paul Davidson, M.D.*

The CTCA was pleased to have the participation of Dr. Kenneth Castro, Director, Division of TB Elimination, and Dr. Zachary Taylor, Chief of TB Field Services, both from the CDC. In their brief speeches, they outlined the IOM report and emphasized the importance of doing well-conducted contact investigations with active TB cases. Dr. Jennifer Flood, from the Surveillance and Epidemiology Section of the CDHS TB Division, outlined the progress that California has made in its efforts to eliminate TB. California still leads all states with the most TB cases – 3,608 in 1999, but with a steadily downward trend in both cases and TB-related deaths. However, deaths due to TB are largely preventable, and coupled with the relatively high percentage of pediatric cases (California contributes 25% of nationwide pediatric TB cases), these signal missed opportunities to further decrease morbidity and mortality from the disease. Dr. Flood emphasized that work toward elimination must include improvements in early case detection and contact investigations in conjunction with targeted testing.

As with previous CTCA conferences, breakout sessions were offered on a variety of TB topics of interest to CTCA members. These four sessions were titled:

1) *Recent Clinical Developments in TB Control,*
2) *Adapting Guidelines for Treatment of LTBI for Local Jurisdictions,*
3) *Screening of Immigrants to the United States, and*
4) *TB Control Programs Outside the United States.*

In addition to breakout sessions,

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Think Incentives and Enablers: Case Studies

Case A

Mr. Apple is a TB 5 who's recently become homeless and is in need of housing. He has a car and has been living in it since he lost his residence. His meals are being provided by a local soup kitchen twice a day. Ordinarily, he works as a day laborer but he doesn't have the energy and stamina that is required for this strenuous work.

Case B

Mrs. Mango is a TB 3 that relies on friends and family members for transportation. She always brings her 10 year-old to clinic with her. Her child is a TB 2 and is currently being treated for latent tuberculosis infection (LTBI). Today, Mrs. Mango's friend dropped her off at the clinic but is unable to transport her back to her residence. She has no other means of transportation.

Case C

Ms. Strawberry is a TB 3 who admits to using heroin and crack and drinking a six pack of beer daily. She has verbalized that she would like to go to rehabilitation. Her housing is unstable and she prostitutes for a living. She has missed multiple daily DOT clinic appointments and neither her Public Health Nurse (PHN) nor a field Community Worker (CW) has been able to locate her. After a week of endless searching a district Public Health Investigator (PHI) locates and brings her into clinic.

Do these cases sound familiar to you? What should you do? Think incentives and enablers. What is the difference between an incentive and an enabler? An incentive makes the desired behavior possible and is perceived as more beneficial to the recipient than the source. Incentives make the desired behavior a high priority in the patient's life, while an enabler allows the patient to do what the provider wants. Incentives motivate the patient and are more effective than enablers. To illustrate the difference, compare bus passes to tokens. Tokens allow the patient to do only what the provider needs - getting to and from clinic. Bus tokens are enablers. With a bus pass, however, the patient is able to go anywhere the Metropolitan Transit Authority (MTA) goes, anytime he/she wishes. This incentive motivates the patient to adhere to directly observed therapy (DOT) because doing so ensures the continuation of a service the patient values.

Incentives and enablers are available to homeless and other indigent pulmonary, extra-pulmonary, and clinically diagnosed tuberculosis patients with suspected or confirmed TB disease, as well as contacts to active TB cases. The available incentives and enablers for TB patients are housing and food provisions, and transportation and rehabilitation services. Eligibility for services does vary slightly according to incentive and/or enabler.

Eligibility for housing requires that the patient be ambulatory and assessed to be homeless or at significant risk of becoming homeless. The patient must be identified as a Class 3 or Class 5 and have three current, consecutive, negative smears. He/she must be placed on and willing to adhere to DOT. Housing vendors are not available in all districts. The Tuberculosis Control (TBC) Program is working diligently to locate vendors in the underserved health districts.

Eligibility for food provisions is similar to that of housing. The patient must be a Class 3 or Class 5 who is assessed to have a need for food. As with housing, the patient must be placed on and willing to adhere to DOT. Only a few districts have independent food vendors. The others rely primarily on McDonald's gift certificates as a food source. Recognizing that $10 in gift certificates per patient per week is too restrictive, the program will be loosening that restriction to $10 in gift certificates per patient per day during the current fiscal year.

Remember Mr. Apple? His public health nurse (PHN) contacted TBC and requested housing and food provisions for him. She received approval for both housing and food provisions on the same day. Currently he is housed at a motel in his health district. He also receives McDonald's gift certificates to supplement the meals that he receives at the soup kitchen.

The transportation provision has expanded from offering only tokens to include the availability of bus passes. Eligibility for tokens requires that the patient be identified as a Class 3 or Class 5, or a contact to an active TB Class 3. Bus passes are available *only* for Class 3 patients. As with housing and food provision requirements, the patient must be placed on and willing to adhere to DOT. In addition, the patient must be assessed as having no reliable or convenient means to get to clinical appointments or clinic-based DOT.

Since Mrs. Mango met eligibility requirements for the transportation provision, her PHN requested and was given approval for her to receive tokens. Her child was also given tokens. Additionally, Mrs. Mango's PHN requested a bus pass for her. She will continue to receive tokens until the bus pass is received.

Substance abuse rehabilitation

services are provided by the Antelope Valley Rehabilitation Centers' (AVRC) Acton branch. While at Acton the patient will receive housing, meals, and rehabilitation services. Eligibility for Acton requires the patient to be at least 18 years-old, be an identified or admitted substance abuser, be sober for at least 24 hours prior to admission, be identified as a current, non-infectious Class 3 or Class 5, have the ability to perform light duty work, have *more than* 90 days of tuberculosis treatment remaining before completion, and be willing to voluntarily admit himself/herself to AVRC.

After serving a few weeks in the county jail, Ms. Strawberry returned to her health district. The clinical staff, CW, PHI, and her PHN did an intervention. AVRC was discussed with her at that time and she decided to voluntarily go to Acton and get clean while completing her TB treatment. Ms. Strawberry's PHN submitted her application for Acton to TBC and it was approved. She is currently receiving rehabilitation services at Acton.

As you can see with the examples of Mr. Apple, Mrs. Mango, and Ms. Strawberry, accessing incentives and enablers is simple. The process involves completing an application, submitting it to the Incentive & Enabler Coordinator (currently Devri Smith), and allowing up to 24-hours for processing.

The application process and all eligibility criteria can be found in the program's newly revised incentive and enabler project procedural manual. It will be distributed to appropriate staff in each health center during upcoming inservices. Meanwhile, if you have any questions regarding the use of incentives and/or enablers, contact Ms. Smith at (213) 744-3110.

Devri E. Smith, PHA

DNC Defense (Central District Experience)

Editor's Note: In recent months, Los Angeles County has confronted an unprecedented number of labor and political issues from political conventions and demonstrations to transportation strikes. During this past summer, Los Angeles hosted the Democratic National Committee's Convention. The following article by Dr. Alvin Chin, Chest Clinician at Central Health Center, provides us with an up-close view of how Dr. Chin and his staff successfully prepared for and responded to some of the challenges stemming from the convention. Recent events demonstrate that the Public Health clinics can confront external challenges to providing clinical services at any time. This lesson provides us with a very important warning for Los Angeles. To minimize disruptions in clinical care and to protect the public's health, all of us must plan and prepare for unexpected challenges and even for those that we can predict.

"Foresight! Foresight! Foresight!"-- Advice given by my former high school counselor on how to avoid disasters. " Not on my shift!"-- Defiant words uttered by the on-call House Staff on the prospect of any particularly critical patient not making it through the night.

D-day minus-3 months: Central District Public Health staff received first information on the subject of safety measures regarding the Democratic National Committee (DNC). Words that attracted attention included "secret service," "intelligence," and "disease surveillance." Filed away.

D minus-1 month: I attended a District Health Officer (DHO) meeting and received updates and more detailed information. Potential impact on patient care being mentioned. Realized that of all the districts, Central (and Satellite Clinic) would be most directly affected. Also realized that if things did go wrong, the whole world would know instantly due to the intense media coverage expected. Retrieved the above file and studied it. Also dug up handouts from Childrens Hospital of Los Angeles (CHLA) Grand Rounds a few months ago on Chemical-Biological Terrorism and its Impact on Children. Checked actual distance from Staples Center to Central; asked Community Worker to do the same from Satellite (both approximately one and a half miles). Mentally calculated how long it takes a well-conditioned organized team of protesters to travel that distance.

D minus-3 weeks: Went over roster of Directly Observed Therapy patients from Satellite and projected their medication needs during the course of the DNC and divided them by stability, reliability and whether they would be daily or bi-weekly. Met with Nursing Management and Facility Supervisor and discussed potential problems and distributed available information including maps. District Public Health Nurse (DPHN) assisted by downloading color maps from www.lacity.org.

D minus-2 weeks: Discussed above during Satellite Team meeting and went through each patient and planned the DOT for the week using input from clinic nurses, DPHNs and CWs. Memo distributed to all Central staff regarding safety measures. The following points were touched upon:

1. Quality health care and public health issues need to be balanced with the safety of staff and patients in mind.
2. Stable and compliant patients to be given the DOT dose the week before, with telephone follow-up if

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DNC, from page 5

necessary (no different from normal procedure if that Monday were a holiday).

3. DPHNs to schedule regular home-visits before or after the convention dates.
4. Pair-up and wear proper ID's. Bring fully charged County-issued or personal cell-phones.
5. Re-stock disaster kits to include water, snacks, torch light, extra clothing, and personal mask.
6. Stay calm and use common sense.
7. Report unusual incidents to supervisors and facility administrator.

D minus-one week: Attended departmental DNC briefing, gathering up-dated information, handouts, and maps. Since the DOT patients at Central more than double that of Satellite, a little more specificity was needed to plan for the delivery. With the help of DPHNs, census tract maps were gathered and compared to maps that showed areas impacted by the DNC. During Team meeting at Central, every DOT patient was discussed using objective data such as distance from the impacted areas, compliance and stability (daily vs. bi-weekly) and subjective data, such as reliability, were compiled. A plan was formulated for the week. Started another file on newspaper clippings regarding various protest groups, city and police preparations, etc.

D-day: Brought my small portable TV, set up in the office, waited for newsbreak. Kept one ear available to listen for sirens along Figueroa Street. I certify that I paid no attention to the female mud wrestlers on daytime talk show; I wrote co-workers' names who would testify to that.

D-day plus one: Feed back from CWs that no delivery was missed although they had to take a circuitous route to avoid the roadblocks. Since there was no proof that they had to go as far as Santa Monica beach before turning back, I will not conduct an official investigation to rescind their mileage for the day.

D-day plus three: One CW told me that driving past riot and police groups was a little too intimidating. I commend their courage for doing this during this difficult week and also during the course of their daily work, without which the County TB rates would not have made such impressive declines in recent years.

Overall, no DOT was missed due to the inconvenience of the DNC, no clinics were canceled, and BA's were no different from usual weeks leading to the occasion. AND IT DID NOT HAPPEN ON MY SHIFT!

P.S. "Defense wins Championships!" – Staples coaching staff.

Alvin Chin MD MPH

Radiology Update

As the end of my first year as Director of Radiology approaches, I thought that I would bring *TB Times* readers up to date on the activities in Radiology. First, the Public Health radiology technologists are now included in the monthly TB educational conferences for which they can receive CME credit.

I have started to hold a series of lectures with the TB clinicians on basic interpretation of chest radio-graphs. An abbreviated inservice was held for nursing staff to cover basic radiology of the chest. A glossary of standard radiology terminology was distributed at these lectures. I am also developing policies and procedures to make the operation of the radiology department more efficient. To facilitate quality assurance, I have standardized the labeling of chest radiographs at all the public health clinics and started a film quality control monitoring system.

For the future, I am working with Dr. James Haughton, Medical Director of Los Angeles County Public Health to develop a screening mammography program. Mammographies will be conducted at public health clinics. I hope that in the upcoming year our department will include improvements in reporting of radiology results.

Anthony Disher, MD

CTCA, from pg. 3

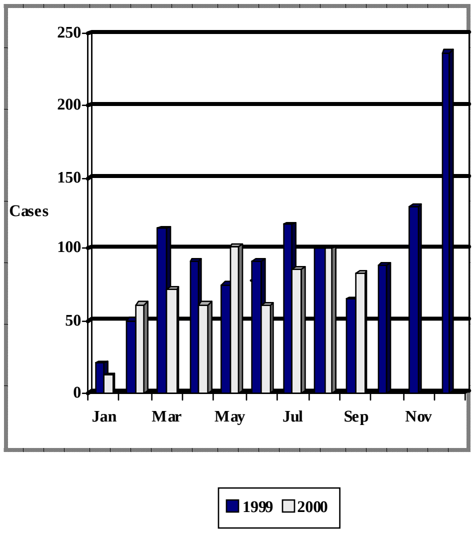
posters, mostly from the state health department, were on display during the 2nd day of the conference.

The next CTCA conference will be April 26-27, 2001 at the Radisson Sacramento. For more information, the CTCA can be reached at (510) 883-6077. The full text of the IOM report is available for viewing online at www.nationalacademies.org/includes/tb.html.

Tuberculosis Cases by Health District Los Angeles County, September 2000 (Provisional Data)						
Service Area	**Service Area Total Year to Date**	**Health District**	**Sep-00**	**Sep-99**	**Year to Date 2000**	**Year to Date 1999**
SPA 1	7	Antelope Valley	2	0	7	15
SPA 2	99	East Valley	2	4	20	29
		West Valley	4	4	42	35
		Glendale	0	2	22	15
		San Fernando	1	3	15	21
SPA 3	109	El Monte	7	4	38	41
		Foothill	2	2	12	12
		Alhambra	5	4	38	46
		Pomona	6	3	21	16
SPA 4	160	Hollywood	7	6	57	71
		Central	10	5	72	81
		Northeast	4	4	31	41
SPA 5	19	West	3	2	19	23
SPA 6	108	Compton	5	2	22	23
		South	3	0	21	19
		Southeast	1	1	21	18
		Southwest	3	4	44	42
SPA 7	75	Bellflower	3	1	24	26
		San Antonio	5	0	29	28
		Whittier	1	1	9	20
		East Los Angeles	3	0	13	18
SPA 8	62	Inglewood	3	2	29	36
		Harbor	2	2	9	9
		Torrance	2	5	24	29
Unassigned	4	Unassigned	0	2	4	5
TOTAL	643		84	63	643	719

Los Angeles County Tuberculosis Incidence

By Month of Report, 1999-2000



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TB Times is a monthly publication providing information to those interested in TB surveillance and TB Control Program activities. Please forward your articles, comments, suggestions or address corrections to:

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